

STRATEGIC MEDICAL LEADERSHIP IN THE GLOBAL WAR ON TERRORISM

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USAWC CLASS OF 2008

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U.S. Army War College, Carlisle Barracks, PA 17013-5050

Report Documentation Page			Form Approved OMB No. 0704-0188		
Public reporting burden for the collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Washington Headquarters Services, Directorate for Information Operations and Reports, 1215 Jefferson Davis Highway, Suite 1204, Arlington VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to a penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.					
1. REPORT DATE 15 MAR 2008		2. REPORT TYPE Strategy Research Project		3. DATES COVERED 00-00-2007 to 00-00-2008	
4. TITLE AND SUBTITLE Strategic Medical Leadership in the Global War on Terrorism			5a. CONTRACT NUMBER		
			5b. GRANT NUMBER		
			5c. PROGRAM ELEMENT NUMBER		
6. AUTHOR(S) Dallas Homas			5d. PROJECT NUMBER		
			5e. TASK NUMBER		
			5f. WORK UNIT NUMBER		
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) U.S. Army War College ,122 Forbes Ave.,Carlisle,PA,17013-5220			8. PERFORMING ORGANIZATION REPORT NUMBER		
9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES)			10. SPONSOR/MONITOR'S ACRONYM(S)		
			11. SPONSOR/MONITOR'S REPORT NUMBER(S)		
12. DISTRIBUTION/AVAILABILITY STATEMENT Approved for public release; distribution unlimited					
13. SUPPLEMENTARY NOTES					
14. ABSTRACT See attached					
15. SUBJECT TERMS					
16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT Same as Report (SAR)	18. NUMBER OF PAGES 30	19a. NAME OF RESPONSIBLE PERSON
a. REPORT unclassified	b. ABSTRACT unclassified	c. THIS PAGE unclassified			

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USAWC STRATEGY RESEARCH PROJECT

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ABSTRACT

AUTHOR: Colonel Dallas W. Homas
TITLE: Strategic Medical Leadership in the Global War on Terrorism
FORMAT: Strategy Research Project
DATE: 21 March 2008 WORD COUNT: 6,694 PAGES: 30
KEY TERMS: Healthcare, Developing Countries
CLASSIFICATION: Unclassified

The Army Medical Department has served our Army's soldiers in the field for centuries. Today, we are engaged in a war on terror, currently focused in the U.S. Central Command's area of operations. Fundamental to winning the hearts and minds of the local populace in countries like Afghanistan and Iraq, and in regions like the Horn of Africa, is ensuring basic human needs. One such need is security, which our armed forces are working towards. Another is health. A person may well be disinterested in how he will be governed tomorrow if he is not sure of being alive and well tomorrow. Therefore, the role of the strategic medical leader is one key to stability in the region and ultimate victory there. This paper examines that medical leader's responsibilities and opportunities in helping to secure a stable environment in our current war on terror.

STRATEGIC MEDICAL LEADERSHIP IN THE GLOBAL WAR ON TERRORISM

Subsequent to the al-Qaeda led attacks on the World Trade Center and the Pentagon on September 11, 2001, the United States has engaged in military action, first in Afghanistan and then in Iraq. Hundreds of thousands of service members have deployed to one or both combat theaters, thousands of whom have died, and tens of thousands of whom have been injured. But to what end? Americans are increasingly wondering how victory, if achievable, will look. In February 2004, deploying soldiers from the 25th Infantry Division (Light) (25th ID(L)) received an address from the US Army Pacific commanding general, Lieutenant General James Campbell. In his message, he noted that victory in Afghanistan would be achieved when the people of Afghanistan came to value their societal institutions more than they feared the Taliban. Once this point was reached, the Afghan people would protect and defend their now-valued way of life, refusing to submit to Taliban rule, and not allowing the Taliban to disrupt their communities. In so doing, sanctuary to terrorist cells would effectively be denied, and the U.S.-led coalition of forces would be at or near victory in this long war on terror.¹

Coalition efforts in Afghanistan and Iraq have focused on both the destruction of terrorist cells and their ability to wage war, as well as on the reconstruction of those nation-states. We have striven to ensure the completion of democratically conducted elections of the nations' leadership. The coalition has worked diligently to build and train an indigenous army and a police force capable of protecting and defending the people. Simultaneously, the coalition's Provincial Reconstruction Teams (PRT) have worked to rebuild the infrastructure destroyed by combat operations. Additionally, the PRTs have gone even further, building roads, schools, water treatment plants, and

medical clinics, far beyond what existed before our kinetic actions in either country. In addition to the physical construction and restoration, the PRTs' efforts also hope to evoke an emotional or psychological effect of winning the hearts and minds of the local populace. Be it a police force, a school house, or a medical clinic, we have, in essence, been attempting to build those societal institutions that the Afghan and Iraqi peoples would come to value and love. So much so, that they would stand up and defy the Taliban, al-Qaeda, or any other disrupting influence. However, as one Special Forces commander said after a difficult combat tour in Afghanistan, "All those un-staffed medical clinics and schools just made sure we had warm and dry Taliban to fight."²

Unfortunately, well-intended military commanders, not realizing that there were insufficient numbers of doctors, nurses, or teachers to staff them, had built the clinics and schools. Perhaps some of this apparent gap in planning resulted from a lack of the U.S. State department and United Nations involvement in the nation-building activities that have now, by default, fallen to military forces on the ground to accomplish – a task for which they are not trained. Another possible reason for our partially mis-guided efforts may rest with the daunting task given to combat leaders who are inexperienced in fighting an asymmetric and irregular battle. In this fight, commanders are responsible for simultaneously destroying the enemy's ability and will to fight, overseeing the reconstruction of their sector's infrastructure, and simultaneously winning over the hearts and minds of the people. Victory in the GWOT will remain elusive until the coalition achieves all three objectives. The Army Medical Department (AMEDD) can play a significant role in facilitating victory, but will require proactive involvement in helping these strained commanders plan and execute some of the nation-building

activities. The purpose of this writing is to discuss senior medical leader roles in the conduct of this war on terror, and to illustrate the critical role that medicine can play in achieving strategic victory.

Historically, the medical officer's role in combat has been fairly well defined. Like the motto of the U.S. Army Medical Command – “To Preserve the Fighting Strength” - the primary role has been to ensure the soldiers involved in the fight were healthy enough to do so. General George Washington, when commanding the Revolutionary Army, stated, “The preservation of a soldier's health should be [the commander's] first and greatest care.”³ To wit, military physicians and other health care professionals have, for centuries, been charged with the responsibility of tending to the health of the force. With the passage of time and incredible advances in science and technology, medical support to the soldier has advanced from a friend or family member administering rudimentary first aid to a field surgeon performing guillotine amputations to the highly sophisticated Combat Support Hospital (CSH) of today. This sophistication comes from an array of diverse assets, including various surgical specialists, richly stocked pharmacies, integral blood banking, and computed tomography (CT) scanning capability. Combat casualty survival has reached previously unimaginable heights, with recent “died of wounds” rates falling to the all-time low of 7.4%.⁴ It seems that military medicine has risen to the challenge of saving lives on the battlefield.

A number of programs exist to ensure the healthy nature of our deploying forces. New soldier accessions are medically screened before entry into military service is allowed. Citizen-Soldiers of the nation's reserve forces are extensively screened and potential deployment-disqualifying ailments are treated within days of their being

mobilized for a combat deployment. Basic preventive medicine programs, immunizations against endemic diseases and against the potential use of weaponized bacteriologic agents, and educational programs about insect vectors and disease prevention in each soldier's projected combat zone are implemented. For example, if deploying to a location where malaria is endemic, service members are required to treat their uniforms with durable insecticides, like Permethrin. Through such efforts, the medical leadership is helping to provide healthy combat forces to the combatant commander responsible for conducting the fight in his area of operations.

As noted above, soldiers injured in the combat theater receive new levels of highly sophisticated medical interventions and are surviving in record numbers. The first step in this enhanced survivability is the existence of the highly trained combat medic, who is able to initiate stabilization and resuscitation of the casualty within minutes of injury. If a medic is not readily available, the fallen soldier has a good chance of being treated by a fellow soldier who has received Combat Life Saver (CLS) training. The 25th Infantry Division, for example, deployed to Afghanistan and Iraq in 2004 with more than 40% of its Infantrymen trained to be Combat Life Savers. Today, all Infantrymen graduating from their Advanced Individual Training are required to be CLS trained. Following such buddy-aide or medic intervention, survival is further significantly enhanced by the swift and competent evacuation of casualties from the battlefield by military medical evacuation (MEDEVAC) helicopter pilots and specially trained flight medics. Waiting surgeons in the forward-deployed Forward Surgical Teams (FST) or in the Combat Support Hospitals offer prompt life-saving interventions. Finally, survival of the injured soldier is bolstered by the rapid jet evacuation of severe casualties to our highest

echelons of medical care in Europe and the United States by the U.S. Air Force. Thus, it is far more than simply competent and caring medical professionals that work to save our injured soldiers - it is truly a system of systems that is enabling military medicine to preserve the fighting strength.

The senior medical leader in a combat environment is typically a member of the commanding general's special staff. His job title is usually cited as the Joint Task Force (JTF) or Combined / Joint Task Force (CJTF) Command Surgeon, based on the branches of U.S. forces present and the presence or absence of international coalition forces. His first responsibility begins at home station, ensuring that the deploying force is medically prepared and protected to board the aircraft bound for the combat theater of operations. He is responsible for ensuring that the unit's combat medics are certified in their specialty, properly equipped, and ready to competently perform their mission in combat. His team also conducts the training and certification of the combat soldiers who receive the additional Combat Life Saver training.

Once in the combat theater, the surgeon's responsibilities grow. First, he retains responsibility for ensuring the good health of the commanding general and the headquarters. Secondly, he oversees all coalition medical assets, advising the commander as to their proper positioning on the battlefield and their utilization to optimize care delivery to units operating in the field. As far as possible, he must maximize cooperation and interoperability of joint medical assets, as well as those of our international partners and those of the host nation. Joint Publication 4-02, Health Service Support, outlines several pages of distinct responsibilities assigned to the Joint

Task Force Surgeon.⁵ In short, the JTF Surgeon is responsible for all aspects of healthcare delivery, surveillance, and healthcare maintenance of the force in theater.

Inherent in this healthcare delivery role is the need for leaders at every level to prevent injury and illness. If a soldier becomes ill or injured to the extent that his ability to perform his duties is sufficiently diminished, the soldier must be evacuated from the combat theater. The Joint Force Surgeon must communicate effectively with his higher chain of command and has an important role in advising the commander and Department of Defense representatives regarding in-theater capabilities and the appropriate theater evacuation time limits.

Combat leaders strive to optimize their soldiers' discipline and training in order to minimize the incidence of battle injuries. However, loss of soldiers from the combat theater due to reasons categorized under "Disease / Non-Battle Injury" (DNBI), are potentially devastating to the combatant commander's ability to effectively execute his mission. According to statistics tracked by the Human Resources Command, nearly six percent of a typical unit will be evacuated from the combat theater during a twelve-month deployment. Of this six percent, only approximately one percent of the evacuated soldiers suffer from injuries sustained as a result of enemy action.⁶ In an attempt to minimize the need to rapidly find and deploy replacement soldiers into theater, the U.S. Army is utilizing a "push replacement system." In this system, a deploying unit is sourced with excess soldiers in the ranks and specialties of those soldiers that are expected to be lost to the unit during its time in combat, based on historical trends.⁷ Accordingly, units are manned at approximately 106% strength as they deploy to combat. These statistics have been the reality for commanders waging

war in both Afghanistan and Iraq for the past several years. Statistics very closely monitored by the 25th ID(L)'s G-1 during near simultaneous deployments to both combat theaters closely mirror those monitored at the Human Resources Command level. Additionally, the 25th ID(L) experienced that once evacuated from the combat theater to a higher echelon of medical care, the likelihood that a soldier returned to duty in the combat theater was approximately 22%⁸ Historically, DNBI has always dominated battle injuries (BI) as a cause of lost combat power. For example, in the Vietnam War, 77 – 87% of all hospital admissions were attributed to DNBI causes, with the majority of lost man-days being attributed to malaria, fevers of unknown origin, and neuropsychiatric conditions.⁹ Of concern in the GWOT is the number of soldiers that potentially could be evacuated for mental health related causes, including stress reactions, depression, and anxiety disorders. A recent report in the New England Journal of Medicine indicates that as much as approximately 16-17% of our fighting force is afflicted by such ailments after combat tours of duty in Iraq or Afghanistan.¹⁰ Often, such mental disorders are not rapidly cured, making return to duty in the combat zone for these soldiers unlikely. Thus, the senior medical leadership in the combat theater can potentially have a significant impact on the combatant commander's ability to accomplish his mission, if the medical personnel and unit leadership are able to prevent or rapidly treat disease and minor illness. Effective medical care, planning, and preparation can prevent evacuation of soldiers from the combat theater. This is especially critical given the known low likelihood of seeing soldiers return to theater after being medically evacuated.

Another challenge facing the strategic medical leader in the combat theater is the healthcare delivery to detainees. It is Department of Defense policy that all persons detained by the Armed Forces of the United States be treated humanely while they are detained. Further, detainees are to receive the same standard of medical care that is offered to members of the U.S. Armed Forces.¹¹ Major General Louis Martinez-Lopez, a senior Army Medical Department representative, inspected detainee healthcare operations in Afghanistan in March 2005. During his exit-brief to this author, he noted that detainee healthcare, a mission that was not resourced in any way, was not being performed adequately. Specifically, he cited deficiencies in providing group therapy, in the detainees' native language, to our detainee population diagnosed with chronic depression. His findings were accurate, as they were in accordance with Department of Defense policy. However, with only an Infantry Division's organic medical assets, representing barely enough medical personnel to care for our combat forces, providing care to a detainee population, which frequently burgeoned into the thousands, proved to be a daunting challenge. Nonetheless, detainee healthcare is truly an area of strategic importance to the medical leader. There has been extensive media coverage of detainee operations in Iraq, at the Abu Ghraib detention facility, and in Guantanamo Bay, Cuba. International opinion of the United States and of her military is potentially swayed by how well or poorly we accomplish this aspect of our mission.

Going beyond the simple provision of healthcare to the detainees, the medical team is also responsible for ensuring compliance with the principles, spirit and intent of international law. Specifically, this compliance includes assurance that medical information about a detainee is not exploited in any way during the interrogation

process.¹² Inherent in the care of detainees is the need to document, both in writing and through photographs, any evidence of suspected detainee abuse. Policies must be established outlining the nature of the medical intake assessment of new detainees, how and where medical records are maintained, how, where, and how frequently care will be rendered, and all other aspects of running a healthcare organization, military or civilian. Unique to this population is the fact that its size can increase by hundreds or thousands in a matter of days and that the population served may well be hostile to the healthcare provider. Additionally, many detainees are brought to the detention facility, interrogated, and deemed to be of no threat to our forces. Such detainees are rapidly repatriated. Medical leadership must emplace and enforce policies and practices that require compassionate and just treatment of all detained persons. These steps can have strategic impact as repatriated detainees share their experience of fair treatment, thereby contributing to favorable local public opinion of U.S. and coalition forces. With the eyes of the world potentially watching, these challenges facing the strategic medical leader surely warrant his full and thoughtful consideration.

Medical outreach to the native population has been shown to be an effective way of endearing the people to the presence of our combat forces. As stated in the U.S. Army and Marine Corps Counterinsurgency Field Manual, “Countering an insurgency begins with understanding the complex environment and the numerous competing forces within it. Gaining an understanding of the environment – including the insurgents, affected populace, and different counterinsurgent organizations – is essential to an integrated [counterinsurgency, aka.] COIN operation.”¹³ Implementation of this concept makes it imperative for our forces to maintain a presence in the local

community. When fighting an enemy that does not wear military uniforms, the astute soldier constantly scans for anything in the community that is new or different. Such noticed changes might well identify the presence of newly arrived insurgents or revived insurgent activity. Thus, military commanders are tasked with knowing their battlespace in detail. They must know the people as well as the physical attributes of their sector.

A program known as the Medical Civil Assistance Program, more commonly known as MEDCAP, was born from a proposal made by the American Embassy in Saigon in 1962, with MEDCAP officially beginning under the Department of the Army in January 1963. The stated purpose of MEDCAP was to provide outpatient care to the Vietnamese civilians, with resultant increase in mutual respect and co-operation between the military forces and the civilian population.¹⁴ In Afghanistan, during Operation Enduring Freedom, many tactical commanders learned rapidly that offering “sick call” to the civilian population was an effective way of gaining access to a previously unreceptive valley or village. Offering healthcare from the back of their tactical vehicles - so-called “tail-gate MEDCAPs” - helped build good will with the populace, and also provided U.S. and coalition soldiers the opportunity to observe their operating environment, looking for the subtle differences that might suggest insurgent presence or activities. Countless anecdotes are told of weapons caches being revealed to U.S. forces after the unit’s medic had effectively treated the village elder’s daughter or another tribal member.

Regional security can also be enhanced through medicine. In one volatile area of Afghanistan, near the Pakistan border, a military vehicle was struck by an improvised explosive device (IED) in 2004. It was commonplace for the military compound in the

area to conduct sick call for the local populace on a daily basis, partnering Afghan doctors with U.S. doctors, physician's assistants, and medics. Following the IED strike, the base commander canceled sick call for a period of time, perceiving the threat to his base as too great, given the recent attack. This decision was conveyed to the village elders. When they realized that allowing the Taliban to place the IED resulted indirectly in the loss of their healthcare, the villagers actively set about ensuring that no further IEDs were placed. After a few weeks of such enhanced security, the military commander resumed the operation of the medical clinic to the delight of the local villagers. In this instance, the Afghan village had done exactly what the USARPAC Commanding General had defined as victory in the GWOT. They had come to value a societal institution – the local medical care – to such an extent that they denied sanctuary to previously active Taliban operatives.

A functional command known as Task Force Victory existed in Afghanistan in 2004-2005. In addition to performing the MEDCAP mission of ambulatory sick call and pediatric immunizations, another of Victory's missions was to perform veterinarian civil assistance activities (VETCAPs) in various strategic sectors across the country. While medical teams would tend to the people, other members of Victory would tend to the health of the herd, de-worming and immunizing the animals. As a society historically based in nomadic herding, the herd is cherished by the people, and represents a significant source of legal wealth in the country. Larger, stronger, and healthier animals, as a result of Task Force Victory's VETCAP efforts, built good will, enhanced the stature and wealth of the herder and his family, and offered hope for a better tomorrow.

Thus, medicine clearly has a role in helping to win the war on terror. Thoughtful preparation of the deploying force, through education, immunization, and other preventive measures assures the combatant commander a healthy force with which he can wage war. Once in the combat theater, active ongoing preventive medicine practices, coupled with competent and swift medical therapies when illness or injury do occur, helps to minimize medical evacuations from theater, thereby enhancing unit size and integrity, and ensuring maintenance of adequate numbers of combat forces in the combat zone. At the tactical level, medical care offered to the local populace can help coalition forces gain entry into unreceptive or distrustful villages, and can facilitate the disclosure of local weapons caches or, in at least one instance, the enhanced assurance of safety from roadside IEDs.

However, such preservation of the fighting force, and the building of favorable relations with the local populace discussed to this point will facilitate victory in the tactical and operational battle. In Hanoi, on 25 April 1975, Colonel Harry G. Summers, Jr., then Chief, Negotiations Division, U.S. Delegation, said to Vietnamese Colonel Tu, Chief, North Vietnamese Delegation, "You know you never defeated us on the battlefield." Only to have the Vietnamese Colonel respond, "That may be so. But it is also irrelevant."¹⁵ Just as one can argue that we were fighting an insurgency in Vietnam, we are currently fighting an insurgency in this Global War on Terrorism. As noted by Sarah Sewell in her introduction to the University of Chicago Press Edition of the U.S. Army and Marine Corps Counterinsurgency Field Manual, "The real battle is for civilian support for, or acquiescence to, the counterinsurgents and host nation government. The population waits to be convinced. Who will help them more, hurt

them less, stay the longest, earn their trust? ... Civilian protection becomes part of the counterinsurgent's mission, in fact, the most important part."¹⁶ The Counterinsurgency Field Manual goes on to say, "Victory is achieved when the populace consents to the government's legitimacy and stops actively and passively supporting the insurgency."¹⁷ This definition effectively echoes the definition of victory in Afghanistan cited by the USARPAC commander some three years earlier. Certainly, the United States, as the sole global hegemony in the early 21st century, fields a military that few, if any, can challenge in the kinetic sense. However, like in Vietnam, it is still possible to lose the war, while never losing a single armed encounter. True victory will remain elusive until the people come to value the government and the societal institutions that the government provides or facilitates.

But which institutions would be valued the most, and therefore, be the first ones upon which to focus? Since early recorded history, man has sought to understand thoughts, behaviors, and motivations. Psychology, the study of human behavior, might have begun as early as 387 B.C., when Plato suggested that the brain was the seat of innate ideas and other mental processes. Various theories have been espoused through the centuries to explain human behavior.¹⁸ In 1970, a psychologist named Abraham Maslow described his theory of human needs driving behavior. Maslow outlines his "hierarchy of needs" in the shape of a pyramid. At the base of the pyramid rests the category of basic physiologic needs, like the need to satisfy hunger and thirst. Stacked above, in the next layer of the hierarchical pyramid, lies the need to feel safe, secure, and stable, with the need to feel that the world is organized and predictable. After achieving safety, security, and stability, comes the layer encompassing the human

need to avoid alienation and loneliness – to belong and be accepted – to love and be loved. Still higher in the hierarchy of needs comes the need for self-esteem, achievement, and respect. At the top of the pyramid lies self-actualization, or the need to live up to one's fullest potential. Maslow subscribes that while the order of needs is not universally fixed, until satisfied, some motivations will be more compelling than others, particularly if the unmet need is lower in the hierarchical pyramid.¹⁹ Maslow's theory has been widely taught for decades, and may provide valuable insight into how our armed forces might pursue victory in the Global War on Terrorism.

According to the U.S. Census Bureau's International Data Base, in 2007, the life expectancy of a person born in Afghanistan is forty-four years. In the same country, one out of every six newborn babies will die before reaching one year of age (infant mortality), while one in every four babies will die before reaching age five years.²⁰ By comparison, the life expectancy of someone born in the United States in 2007 is seventy-eight years. The infant mortality in the U.S. is one out of every 167 newborns, and the 5-year mortality shows that only one in 125 babies will die.²¹ For further comparison, additional data is shown below, in Table 1, for Iraq, and for the four countries that comprise the Horn of Africa, the other region in the U.S. Central Command's area of responsibility (CENTCOM AOR). While none of these countries is as forlorn as Afghanistan, none demonstrate the hope for survival that is present in the United States.²² There is room for improvement in the odds that an Afghan, Iraqi, or Horn of Afrikaner's child will live to see adulthood and room for improvement that each adult will live to see his grandchildren.

	Life Expectancy	Infant Mortality, <1y	Mortality < 5y
United States	78 y	1: 167	1: 125
Afghanistan	44 y	1: 6	1: 4
Iraq	69 y	1: 21	1: 17
Djibouti	43 y	1: 10	1: 6
Ethiopia	49 y	1: 11	1: 7
Eritrea	60 y	1: 22	1: 13
Somalia	49 y	1: 9	1: 5

Table 1. Mortality Statistics of states within the CENTCOM AOR compared to those of the U.S.

In this room for improvement lies an opportunity. As Ms. Sewell, when writing of victory in counterinsurgency operations noted above, “The real battle is for civilian support.... The population waits to be convinced. Who will help them more, hurt them less... earn their trust.”²³ Here lies an opportunity for the strategic medical leader to contribute directly to victory in the counterinsurgency that is the Global War on Terrorism. In accordance with Maslow’s hierarchy of needs, fundamental or basic needs usually must be met before the individual feels compelled to address more sophisticated needs. As such, an Afghan herder most likely will not care whether or not a democratic government is in place and thriving in Kabul, Afghanistan, if he is immersed in a daily struggle for survival, uncertain of living to see his children grow, or if only one in four of his children will survive to age five years. If, however, that same government in Kabul implements policies and practices that result in a better life for the herder, he may well come to care greatly for the government. The offering of healthcare

can be a significant step toward showing the people who will help them more, hurt them less, and earn their trust. It has been seen repeatedly at the tactical level that the local populace in Afghanistan wants healthcare. But to truly have a chance at winning the war and not just the tactical battle, actions must occur at the strategic level.

It is imperative that the strategic medical leader go beyond his historic role of “preserving the fighting strength.” He must also endeavor to improve the healthcare delivery to the local people, not through his own initiatives, but rather, through his interactions with the host nation’s leadership. Implementation of preventive medical measures for the combat force and treating illness and injury when they present might be viewed as operating “defensively.” As discussed, such activities surely contribute to the operational victory. However, to affect strategic victory, the AMEDD must proactively operate on the “offensive” to contribute to the strategic fight. The military medical leader, either with or without a U.S. Health and Human Services or other Department of State representative, must seek out opportunities to interface with the Minister of the Interior or the Minister of Health of the host nation’s newly formed government. In these meetings, discussions centered on improving the health of the local populace can take place.

However, the new Minister of Health may not know how to proceed. Medicine is a vast field, with extensive technologic attributes. Accordingly, discussions should focus on achievable advances and prioritization of efforts. However, as noted by health care researchers Lydia Kipiriri and Douglas K. Martin, “Because the demand for health services outstrips the available resources, priority setting is one of the most difficult issues faced by health policy makers, particularly those in developing countries.”²⁴

These researchers contend that such decisions are values laden and must be made by legitimate people and that the influences of a few “powerful” and possibly corrupt individuals must be mitigated.²⁵ They further assert that fair priority setting ensures that four conditions – relevance, publicity, revisions, and enforcement - are met.

“Relevance” is satisfied if the decisions are ethically based and apply to the targeted stakeholders. “Publicity” is satisfied if the priority setting decisions and their rationale are made known to the public. “Revisions” implies that there are mechanisms to change decisions in light of new information, and “enforcement” mandates the existence of leadership that will ensure the first three conditions are met.²⁶ So often, poor healthcare delivery is attacked by allotting more and more materiel resources to the problem. These resources are frequently mismanaged in one way or another. Some are pilfered, some are sold on the black market, and some are permitted to expire, unused, in storage facilities. Efforts aimed at more effective management of healthcare delivery, at each level, with a mind to the four conditions noted above, would make great strides forward in improving the healthcare standard in most developing countries. The strategic military medical leader needs to understand his environment and the capabilities of the local populace, and work with the host nation leadership to establish medical programs that meet these or other fair priority-setting standards.

Dr. Halfdan T. Mahler served as Director General of the United Nations’ World Health Organization for 15 years. As such, he has insights into healthcare in developing countries shared by relatively few medical personnel the world over. When speaking of the abysmal infant mortality statistics like those noted above, he remarked, “These statistics are a grim index of underdevelopment, and a shocking reflection of the

medical system's failure to protect human existence in its vulnerable beginning stage."²⁷

Dr. Mahler, cognizant of the poverty that usually exists in such countries, advocates a focus on primary health care, above expensive medicines and technologies. Education of prospective mothers with regards to the intake of leafy vegetables and other simple nutritional counseling can greatly enhance fetal health.²⁸ In Afghanistan, for example, women, upon realizing that they were pregnant, would frequently begin to starve themselves. They did this in order to have as small a baby as possible, thereby increasing their own chance of surviving the birthing process. This practice was encouraged by the other women in the tribe, and was developed as a way to mitigate the chance of maternal death during childbirth.²⁹ Given such an environment, the strategic military medical leader, when engaging with the host nation's leadership, would not focus on sophisticated maternal-fetal units with technologically advanced equipment. Rather, the discussions might focus on the establishment of a program offering basic nutritional counseling to expectant mothers and the establishment of a midwifery training program.

Dr. Mahler, speaking of healthcare in India, refers to "making greater use of 'barefoot doctors' – the quasi-medical personnel with roots in their communities." "The [midwives], though entirely illiterate, have extensive rapport with the people in their communities... and can perform such simple yet significant tasks as monitoring the weight of babies."³⁰ The same concept applies to any developing country. For example, the literacy rate in Afghanistan is approximately 28%, with 43% of men and only 12.6% of women being able to read and write a simple sentence.³¹ Further, in the North American edition of *Lancet*, authors Setel, Macfarlane, and Szreter relate, "Most

people in Africa and Asia are born and die without leaving a trace in any legal record or official statistic. Absence of reliable data for births, deaths, and causes of death are at the root of this scandal of invisibility, which renders most of the world's poor as unseen, uncountable, and hence uncoun­ted.”³² Promoting health in countries ravaged by illiteracy and war represents a significant challenge potentially requiring the creation of elementary record keeping processes before the work of delivering healthcare can officially commence. Naturally, some countries will have greater literacy rates and better infrastructure available than Afghanistan. Each area of operations must be evaluated for its inherent assets and level of functioning, and recommendations made to the country's leadership accordingly.

Perhaps the greatest medical concern in developing or war-torn countries is the lack of clean water. “Every 14 seconds, someone in the world dies from a disease caused by contaminated water. Of the 2 million children, women and men affected each year, most victims are under the age of five. Everywhere, limited access to clean drinking water threatens the well-being of millions of people.”³³ The World Health Organization's Dr. Mahler notes that in most developing countries, only a small minority is served by piped water, even in urban areas.³⁴ In many developing countries, it is not uncommon to see the same water source used by humans and animals. Further, the same water source is used for bathing, cooking, recreation, and the elimination of human waste. Such was the case in a remote region of Cambodia visited by a U.S. Army team during a 2003 humanitarian aid mission.³⁵ In some instances, even if the people are educated regarding the benefits of boiling their cooking and drinking water, their impoverished state precludes them from having the money needed to acquire the

fuel necessary to do so. In Afghanistan, PRTs around the country have drilled many wells in an attempt to provide villages with safe water for drinking and cooking. In Bagram, Afghanistan, the military has built a bottled water plant to provide safe drinking water to the local populace. Such efforts may well have a profoundly positive effect on the health of the Afghan people. Like the medical clinic conducted at one forward operating base, these efforts can and do endear the local populace to the coalition's presence in the area. However, these types of activities, if undertaken by the Afghan government, with the covert advice and support of the coalition, would yield greater gains in ultimately winning the war on terror in Afghanistan. If the populace sees such benefits as coming from their government, they may come to value and support the government, thereby weakening the insurgents' position.

Numerous possibilities exist to enhance the lives of the people in war-torn countries undergoing reconstruction. City planners and engineers restore or create anew, buildings and roads and electricity grids, PRTs build schools and medical clinics and dig wells, and MEDCAPs and VETCAPs seek to help people and herd-animals alike. To preclude these schools and clinics from serving as shelters for Taliban fighters, advisors to the host nation leadership must advocate another type of "capacity building." Educational programs to overcome the extreme illiteracy rate should be established by the government. Staffing of the schools should be forecast, before the schools are constructed. Similarly, personnel need to be identified to staff the medical clinics, in locations identified by the government, to serve the local tribes. In many instances, the clinic may be staffed by illiterate midwives or elementary medics, who have received the most basic medical training. This training might include such

practices as urging expectant mothers to eat nutritious foods, keeping track of a newborn baby's weight, offering someone with severe diarrhea clean water mixed with a small amount of sugar and salt to deter dehydration, keeping some form of record of who in the village was immunized this year, and similar simple but potentially profoundly effective interventions.

The senior medical leader, if willing to step beyond his historic role of preserving the fighting force, can be the person to engage host nation leadership and encourage the establishment of such programs. Clearly, an understanding of preventative medicine and primary health care is important, but even if the CJTF Surgeon lacks this knowledge, he can summons such expertise from colleagues and via the immense reach-back capabilities available within the various coalition countries.

The medical leader has a number of roles in helping to secure victory in the Global War on Terrorism. First, he must ensure the combatant commander has forces that are fit to fight. This mission begins before ever entering the combat zone, with medical screenings and interventions to optimize the health of the force. Additionally, the force must be educated about endemic disease in their combat area of operations, and be protected from such threats. Once in the combat zone, effective management of disease and injury, with resultant minimization of medical evacuation out of the combat theater, keeps units near optimal strength and enhances unit integrity. Proper placement of medical assets across the battlespace optimizes prompt treatment of coalition soldiers, and if required, medical evacuation of severely ill or injured soldiers to higher echelons of care, both in and out of the combat theater, promotes survival. Effective implementation of medical programs and assets contribute greatly to the fight.

As noted in the U.S. Army and Marine Corps Counterinsurgency Field Manual, when speaking of Salvadoran counterinsurgency forces, "... morale improved noticeably when soldiers knew that, if they were wounded, MEDEVAC helicopters would get them to a hospital in minutes. With this air support, [they] became much more aggressive in tracking down and engaging insurgents."³⁶ Through his efforts, the senior military medical leader can contribute significantly to success on the ground in the war on terror.

Secondly, going beyond facilitating victory in the tactical and operational fight, the strategic medical leader can contribute to victory in the war. In this sense, strategic victory is achieved when the populace of the involved country allies with the government of that country, thereby disavowing support to the insurgent presence in their locale. In a recent article published by the Associate Press, White House spokesman Tony Fratto referred to just such a victory when he was quoted, "The Iraqi people – every day, and in increasing numbers – are choosing freedom and standing against the murderous, hateful ideology of AQI (al-Qaeda in Iraq). And we stand with them."³⁷ The medical leader, in this regard, has influence in helping to win the "hearts and minds" of the local populace. He can take some steps toward this goal through the establishment of policies that require the fair and humane medical treatment of detainees. Such just treatment of those detainees released back to their villages can sway some locals to the side of the coalition and the host nation government.

Most importantly, though, the strategic medical leader can affect potentially profound advances through his mentoring of the host nation's leadership in establishing medical programs that positively impact the health and well being of the populace. The AMEDD has stated that support to the GWOT is its top priority. As such, the mission

must be appropriately resourced with the right people. Since January 2007, the top two military medical positions in Iraq have been held by the same “dual-hatted” person. The focus of the Corps-level surgeon (Multi-National Corps – Iraqi or MNCI) is support to the operational and tactical forces in the field. The focus of the strategic-level surgeon (Multi-National Forces – Iraq or MNFI) is interfacing with the Iraqi government to build national capacity in healthcare delivery. The same paradigm existed in Afghanistan, with the operational-level CJTF surgeon being dual-hatted as the former strategic-level Combined Forces Command – Afghanistan (CFC-A) surgeon. When tasked with two full-time and disparate missions, the natural tendency is to focus on the historical role of preserving the fighting force – taking care of our warriors in the field. Such under-resourcing of the strategic level mission is a mistake. Helping the host-nation government establish technologically simple programs focused on providing basic nutritional education, preventive medicine awareness, and rudimentary primary care can address many fundamental human needs. Working with city planners and engineers, encouraging projects to provide safe, clean drinking water would eliminate many devastating diseases. Helping to establish national training wherein grassroots health care providers are educated in simple ways to help their tribes would bring healthcare to the villages now, while more formal medical education and other capacity building is occurring. With such basic needs being met through actions of their government, the people can gradually come to have hope for a better tomorrow. When not embroiled in a struggle for daily survival, they can come to see personal gain through their support for their government, perhaps to the point that they deny the insurgents in their midst. As this conscious allegiance to the government occurs, one

person at a time, one village at a time, victory in the Global War on Terrorism is achieved.

Endnotes

¹ Personal recollection of statements made by speaker at pre-deployment address, given to deploying members of the 25th Infantry Division (Light), Schofield Barracks, Hawaii, February 2004.

² COL Paul Burton, commander of Task Force 71, Combined Special Operations Task Force, engaged in combat in Afghanistan during Operation Enduring Freedom, March 2004 – December 2004, interview by author, 10 December 07.

³ U.S. Joint Chiefs of Staff, *Health Service Support*, Joint Publication 4-02 (Washington D.C.: U.S. Joint Chiefs of Staff, 31 October 2006), I-1.

⁴ Lt. Gen. James G. Roudebush, “Today’s Commitment: Transforming Military Medicine,” speech delivered at the 2006 Air Force Defense Strategy and Transformation Seminar Series, (Washington, D.C., 15 November 2006).

⁵ Joint Publication 4-02, II-1 – II-8.

⁶ LTC Mike Pannell, U.S. Army Human Resources Command, interviewed telephonically by author, 8 January 2008.

⁷ Ibid.

⁸ COL Patrick Rice, former G-1 25th Infantry Division (Light), who served with that unit 2004-2006, during the unit’s deployments to Afghanistan and Iraq, interview by author, 10 January 2008.

⁹ LTG Spurgeon Neel, *Vietnam Studies – Medical Support of the U.S. Army in Vietnam – 1965-1970* (Washington, D.C.: U.S. Government Printing Office, 1973), 33-34.

¹⁰ Charles W. Hoge, Carl A. Castro, Stephen C. Messer, Dennis McGurk, et al., “Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care,” *The New England Journal of Medicine*, 351 (1 July 2004):13.

¹¹ Joint Publication 4-02, Ch IV, paragraph 6, sections c and f. IV-19 – IV-20.

¹² Ibid., Para 6, section f, pg IV-20 – IV-21.

¹³ *The U.S. Army and Marine Corps Counterinsurgency Field Manual*, with forewords by General David H. Petraeus and Lt. General James F. Amos, para 2-14. pg 58.

¹⁴ Neel, 164.

¹⁵ Harry G. Summers, Jr., *On Strategy – a Critical Analysis of the Vietnam War* (New York: Random House Publishing Group, 1982), 1.

¹⁶ Sarah Sewell, "Introduction" to *The U.S. Army and Marine Corps Counterinsurgency Field Manual*, with forewords by General David H. Petraeus and Lt. General James F. Amos (Chicago: University of Chicago Press, 2007), xxv.

¹⁷ Ibid., 6.

¹⁸ David G. Myers, Ph.D., *Psychology*, 7th ed. (New York: Worth Publishers, 2004), Paraphrased from Prologue, 1-9.

¹⁹ Ibid., 458-459.

²⁰ U.S. Census Bureau International Data Base (IDB), *Country Summary: Afghanistan; Life Expectancy and Mortality Rates*, available from <http://www.census.gov/ipc/www/idb/country/afportal.html>; Internet; accessed 21 December 2007.

²¹ U.S. Census Bureau International Data Base (IDB), *Country Summary: United States; Life Expectancy and Mortality Rates*, available from <http://www.census.gov/ipc/www/idb/country/usportal.html>; Internet; accessed 21 December 2007.

²² Statistics for additional countries found in *Country Summaries* within U.S. Census Bureau International Data Base (IDB), available from <http://www.census.gov/ipc/www/idb/country/izportal.html>; (Iraq); <http://www.census.gov/ipc/www/idb/country/djportal.html>; (Djibouti); <http://www.census.gov/ipc/www/idb/country/etportal.html>; (Ethiopia); <http://www.census.gov/ipc/www/idb/country/erportal.html>; (Eritrea); Internet; accessed 21 December 2007.

²³ Sewell, xxv.

²⁴ Lydia Kapiriri and Douglas K. Martin, "A Strategy to Improve Priority Setting in Developing Countries," *Health Care Analysis* 15 (1 March 2007): 159.

²⁵ Ibid., 161-162.

²⁶ Ibid., 163.

²⁷ Darryl D'Monte, "A Low-Tech Approach – Prescriptions for Third World Health," *The New Leader* 71 (2 May 1988): 13.

²⁸ Ibid.

²⁹ Personal experience of the author, gained while serving in Afghanistan March 2004 to March 2005.

³⁰ D'Monte, 14.

³¹ U.S. Central Intelligence Agency, *The World Factbook – Afghanistan; Literacy Rates* available at <https://www.cia.gov/library/publications/the-world-factbook/geos/af.html>; Internet; accessed 23 January 2008.

³² Philip W. Setel, Sarah B. Macfarlane, and Simon Szreter, "The Scandal of Invisibility: Making Everyone Count by Counting Everyone," *Lancet* 370 (3-9 November 2007): 1569.

³³ "Contaminated Water Is Like a Big Elephant in Rural Africa," linked at *Outreach International's* website, available from http://www.outreach-international.org/site/PageServer?pagename=hcd_elephants; Internet; accessed 23 January 2008.

³⁴ D'Monte, 14.

³⁵ Personal experience of the author during a Blast Resuscitation and Victim Assistance (BRAVA) mission to Pailin, Cambodia in 2003.

³⁶ *U.S. Army and Marine Corps Counterinsurgency Field Manual*, paragraph E-3, 364.

³⁷ Salah Nasrawi of the Associated Press, "Tape: Holy War to be Expanded," *Sunday Patriot-News* (Harrisburg, PA), 30 December 2007, sec. A, p. 12.